



CERTIFICATE OF DEATH

18813

1. Name of deceased

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

13722  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14576

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton, R.D.3	
c. LENGTH OF STAY IN 1b 22 hrs+		d. STREET ADDRESS 1 Rural	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James D. Cava		4. DATE OF DEATH Month Day Year 12-12-60 19	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-11-1887
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Resurant Busness		10b. KIND OF BUSINESS OR INDUSTRY 1	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthony D. Cava		14. MOTHER'S MAIDEN NAME Rosa Archbald	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 048-26-2105	
17. INFORMANT Address Union Hospital Records. Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal Hemorrhage with fracture of Hyoid bone 981x DUE TO (b) Bullet wound of the head. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Was shot by a 22 rifle Cecil Md	
20c. TIME OF INJURY Month, Day, Year 2:50 a.m. 12 11 60		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Apartment house Elkton Cecil Md.	
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rising Sun, Md. 12-13-60	
22a. BURIAL, CREMATION, REMOVAL, etc. Dec 16, 1960		22b. DATE THEREOF Dec 16/60	
22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception Cem.		22d. LOCATION (City, town, or county) (State) Elkton, Maryland	
23. FUNERAL DIRECTOR Reph E. Hicks		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
ADDRESS Elkton, Maryland		JAN 12 '61 Arthur S. Kraus	

MEDICAL CERTIFICATION

352

1992

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7-201-01-01

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Nov

13723 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13695

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md. b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dr. J.L. Johnson 245 E. High St. On the way to Dr. office			d. STREET ADDRESS 1125 Booth St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Kim Yette Congo			4. DATE OF DEATH 12 23 19 60		
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9-29-60		9. AGE (in years last birthday) 12 yrs. IF UNDER 1 YEAR Months 3 Days 6 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wilmington, Del.	
13. FATHER'S NAME Howard Congo, Jr.			14. MOTHER'S MAIDEN NAME Lucille Braywood		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Lucille Congo. 125 Booth St. Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Gas 890.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Gas from Coal Stove			
20c. TIME OF INJURY Month, Day, Year during high 12-23-60 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> al work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 125 Booth Elkton Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R.C. Dodson		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rising, Sub Md.		DATE SIGNED 12-23-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/60		22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cem.	
23. FUNERAL DIRECTOR John P. Bell		ADDRESS 909 Poplar St.		24a. REC'D BY REGISTRAR DEC 29 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

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NOTES

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13696

Reg. Dist. No.

13724

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> d. STREET ADDRESS <u>120 Norman Allen Ter. Holly Hall</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>William Edwin Conway</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>12 17 19 60</u>	

5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-1890</u>	9. AGE (In years last birthday) <u>70</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barber shop owner</u>		11. BIRTHPLACE (State or foreign country) <u>Md. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13. FATHER'S NAME <u>John E. Conway</u>	14. MOTHER'S MAIDEN NAME <u>Sarah Allen</u> <del>Earline Crouch Moore</del>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>216-03-7866</u>
17. INFORMANT Address <u>Hall, Elkton, Md</u> <u>Mrs. Betty Moore, 20 Norman Allen Ter. Holly</u>	

<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH   
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	

21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED <u>12-18-60</u>
ACTUAL SIGNATURE <u>R.C. Dodson</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 20, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Nr. Chesapeake City, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME Donald W. De</u>		24a. REC'D BY REGISTRAR <u>DEC 28 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13697

13725

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>New Castle</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newark</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Devine Nursing Home</b>		d. STREET ADDRESS <b>105 Bent Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>F.</b> Last <b>Cronin</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>18</b> , Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 9, 1876</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John E. Fry</b>		14. MOTHER'S MAIDEN NAME <b>Helen M. Hellen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, state or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>John H. Cronin</b>		Address <b>105 Bent Lane, Newark, Del.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Glaucoma, bilateral</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept. 24</b> , 1960, to <b>Dec. 18</b> , 1960, that I last saw the deceased alive on <b>Dec. 18, 1960</b> , at <b>11:25 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Wallace M. Johnson</b> M.D. <b>257 E. Main Street, Newark Dela</b> <b>12/19/60</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Wallace M. Johnson M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 21, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Gracelawn Mem. Pk.</b>	22d. LOCATION (City, town, or county) (State) <b>Farnhurst, Del.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. T. Jones</b>		24a. REC'D. BY REGISTRAR DATE <b>DEC 27 '60</b>	
ADDRESS <b>Newark, Del.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. H.</b>	

CERTIFICATE OF DEATH

Name of Deceased John W. Brown		Sex Male		Race White	
Date of Birth Dec. 15, 1895		Date of Death Dec. 15, 1955		Age 60 years	
Place of Birth Baltimore, Md.		Usual Residence Baltimore, Md.		Cause of Death Heart Disease	
Occupation Clerk		Marital Status Married		Signature of Physician J. W. Brown	
Signature of Informant J. W. Brown		Signature of Registrar J. W. Brown		Date of Registration Dec. 15, 1955	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13744

## CERTIFICATE OF DEATH

Reg. Dist. No.

13698

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY New Castle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural North East		c. LENGTH OF STAY IN 1b 5 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Zion, R. F. D. No. 1		d. STREET ADDRESS 801 Lore Ave., Gordon Hgts. 46X-3	
3. NAME OF DECEASED (Type or print) First Emma Middle Bottomley Last Dalby		4. DATE OF DEATH Month 12 Day 28 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1880
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herbert W. Ouseley		14. MOTHER'S MAIDEN NAME Rebecca Rhoys	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Richard C. Rhodes, Address 2507 Washington Avenue, Claymont, Delaware			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 156.1 DUE TO (b) Carcinoma of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 wks approx. 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11, 1960 to 12/28, 1960, that I last saw the deceased alive on 12/28, 1960, and that death occurred at 3A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Neil Taylor M.D.		ADDRESS (Street, city or town, state) Rising Sun, Md	
PHYSICIAN'S NAME (Type) Neil Taylor Jr.		DATE SIGNED 12/28/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/60	
22c. NAME OF CEMETERY OR CREMATORY Chester Rural Cem.		22d. LOCATION (City, town, or county) (State) Delaware County, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert S. McCrery		ADDRESS Wilmington, Delaware	
24a. REC'D BY REGISTRAR DATE JAN 4 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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3. Bottom layer - yellow

Government of India  
Hobart, Tasmania

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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13741

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13699

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		c. LENGTH OF STAY IN 1b 43 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 130 S. Main St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit	
3. NAME OF DECEASED (Type or print) First Middle Last Nellie N. Eberhardt		4. DATE OF DEATH Month Day Year Dec. 5 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1881
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY General Store	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Hitchens		14. MOTHER'S MAIDEN NAME Hannah Harrigan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-24-5513	
17. INFORMANT Mrs. Norman Hasson, Port Deposit, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Massive Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis (c) Coronary in Situ DUE TO 10 minutes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 2 1960, to Dec 4 1960, that (I) (we) last saw the deceased alive on Dec 3 1960, and that death occurred at 9:22 AM, from the causes and on the date stated above.			
22a. SIGNATURE G.H. Richards Jr.		22b. DATE SIGNED 12/7/60	
22c. PHYSICIAN'S NAME (Type) G.H. Richards Jr. M.D.		22d. ADDRESS Port Deposit, Md.	
23a. BURIAL, CREMATION, OR OTHER FINAL Disposition (Specify) Burial		23b. DATE THEREOF 12-8-1960	
23c. NAME OF CEMETERY OR CREMATORY Silver Brook		23d. LOCATION (City, town, or county) (State) Wilmington, Delaware.	
24. FUNERAL DIRECTOR'S SIGNATURE Cecelia Patterson		25a. REC'D BY REGISTRAR DATE DEC 8 '60	
ADDRESS Perryville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hinkle	

1941

CERTIFICATE OF DEATH

1941



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13726

CERTIFICATE OF DEATH

Reg. Dist. No.

13700

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKTON</b> c. LENGTH OF STAY IN 1b <b>7 hrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>UNION HOSP</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL North East</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Barry</b> Middle <b>Boy</b> Last <b>EDWARDS</b>		4. DATE OF DEATH Month <b>12</b> Day <b>15</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-15-1960</b>
9. AGE (In years lost birthday) yrs. <b>7</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ROLAND EDWARDS</b>		14. MOTHER'S MAIDEN NAME <b>VIRGINIA SULLENS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b> (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>ELKTON MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>776X</b> IMMEDIATE CAUSE (a) <b>Premature birth precipitated by fall on ice by mother</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>on ice by mother</b> DUE TO (c) <b>on ice by mother</b> INTERVAL BETWEEN ONSET AND DEATH <b>17 hrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>11:35p</b> p. m. <b>12</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 15</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Dec. 15</b> , 19 <b>60</b> , and that death occurred at <b>11:35p</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. Ralph Andrews, Jr.</b>		ADDRESS (Street, city or town, state) <b>233 E. Main Street</b> DATE SIGNED <b>12/16/60</b>	
PHYSICIAN'S NAME (Type) <b>S. Ralph Andrews, Jr., M.D.</b>		<b>Elkton, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-16-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Rising Sun Rd. Cecil Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Frank</b>		24a. REC'D BY REGISTRAR <b>DEC 19 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

2065171XVO

CERTIFICATE OF DEATH

1921

Married

Native

White

Male

Edward

John

12-15-1900

MADE WHITE

MARYLAND

Edward F. DOWERS VIRGINIA

HOSPITAL VIRGINIA

12-15-1900

1921

1921

1921

1921

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13745

CERTIFICATE OF DEATH

Reg. Dist. No.

13701

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL NORTHEAST</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL NORTH EAST</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>FLORA</u> Middle <u>L.</u> Last <u>ENGLAND</u>		4. DATE OF DEATH Month <u>12-</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-30-1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>MONTILLION MASON</u>		14. MOTHER'S MAIDEN NAME <u>LYDIA E PIERCE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Ella Leonard North East Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x Hypertensive Cardio Vascular Renal Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month <u>-</u> Day <u>19</u> Hour a. m. <u>-</u> p. m. <u>-</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept.</u> 19 <u>49</u> to <u>13 Dec</u> 19 <u>60</u> , that I last saw the deceased alive on <u>5 Dec</u> 19 <u>60</u> , and that death occurred at <u>6:40 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Klaus H. Huchner</u>		DATE SIGNED <u>12/13/60</u>	
PHYSICIAN'S NAME (Type) <u>Klaus H. Huchner M.D.</u>		ADDRESS (Street, city or town, state) <u>North East, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-17-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rosebank</u>	22d. LOCATION (City, town, or county) (State) <u>Calvert Cliffs Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grand</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 21 '60</u>	
ADDRESS <u>North East Md</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. S. Rouse</u>	

1955

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. NAME OF DECEASED <i>John F. Kennedy</i>		2. PLACE OF BIRTH <i>Brooklyn, New York</i>	
3. DATE OF BIRTH <i>May 29, 1917</i>		4. SEX <i>Male</i>	
5. RACE <i>White</i>		6. OCCUPATION <i>President of the United States</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF DEATH <i>June 5, 1963</i>	
9. TIME OF DEATH <i>9:58 AM</i>		10. PLACE OF DEATH <i>Washington, D.C.</i>	
11. CAUSE OF DEATH <i>Assassination</i>		12. MANNER OF DEATH <i>Homicide</i>	
13. MEDICAL HISTORY <i>None</i>		14. PREVIOUS ILLNESS <i>None</i>	
15. SIGNATURE OF PHYSICIAN <i>John F. Kennedy</i>		16. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
17. SIGNATURE OF WITNESSES <i>John F. Kennedy</i>		18. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
19. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		20. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
21. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		22. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
23. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		24. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
25. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		26. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
27. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		28. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
29. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		30. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
31. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		32. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
33. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		34. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
35. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		36. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
37. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		38. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
39. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		40. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
41. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		42. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
43. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		44. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
45. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		46. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
47. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		48. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
49. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		50. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
51. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		52. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
53. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		54. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
55. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		56. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
57. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		58. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
59. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		60. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
61. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		62. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
63. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		64. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
65. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		66. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
67. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		68. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
69. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		70. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
71. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		72. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
73. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		74. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
75. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		76. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
77. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		78. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
79. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		80. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
81. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		82. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
83. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		84. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
85. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		86. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
87. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		88. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
89. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		90. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
91. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		92. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
93. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		94. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
95. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		96. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
97. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		98. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	
99. SIGNATURE OF DECEASED <i>John F. Kennedy</i>		100. SIGNATURE OF DECEASED <i>John F. Kennedy</i>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13746

13702

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural		c. LENGTH OF STAY IN 1b 40 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chestnut Grove				d. STREET ADDRESS Chest Nut Grove		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Alice Flaharty				4. DATE OF DEATH Month Day Year Dec. 13 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 3, 1905		9. AGE (In years last birthday) yrs. 55	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Huss				14. MOTHER'S MAIDEN NAME Laura Ritchie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs Paul Linton, Port Deposit, Md. Rural			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Myocarditis (c) Generalized Atherosclerosis						INTERVAL BETWEEN ONSET AND DEATH 10 1/2 hours 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-7 1958 to 12-13 1960 that (I) (we) last saw the deceased alive on 12-13 1960, and that death occurred at 3:30 PM, from the causes and on the date stated above.							
22a. SIGNATURE G.H. Richards Jr. M.D.				22b. ADDRESS Port Deposit, Md.		22c. DATE 12/14/60	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF 12-16-1960		23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove, Cem.		23d. LOCATION (City, town, or county) (State) Pleasant Grove, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Cecilia Patterson & Sons, Perryville, Md.				25a. REC'D BY REGISTRAR DATE DEC 16 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1874



*[Faint, mostly illegible text and lines forming a form structure, likely containing fields for name, date, and cause of death.]*

## CERTIFICATE OF DEATH

Reg. Dist. No.

14577

13727

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 5 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Wesley Last Freeman				4. DATE OF DEATH Month December Day 14 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 17, 1910	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rubber mixer				10b. KIND OF BUSINESS OR INDUSTRY Plasticoid Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward T. Freeman				14. MOTHER'S MAIDEN NAME Annie Carroll			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 222-05-4295		17. INFORMANT Address Temple Freeman, Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the cervix with metastasis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 10, 1960, to Dec. 14, 1960, that I last saw the deceased alive on Dec. 14, 1960, and that death occurred at 1 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Tillman D. Johnson</i> M.D. December 15, 1960 PHYSICIAN'S NAME (Type) Tillman D. Johnson M.D. 1735 S. S. 17th, Elkton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/60		22c. NAME OF CEMETERY OR CREMATORY Chesterville Cemetery		22d. LOCATION (City, town, or county) (State) Chesterville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph E. Hicks</i> ADDRESS Elkton, Md.				24a. REC'D BY REGISTRAR DATE JAN 13 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13752

Reg. Dist. No. 1

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		MALE		65		JAN 15 1880		BALTIMORE		MD		MD		USA	
RACE		COLOR		RELIGION		EDUCATION		OCCUPATION		MARRIED		SINGLE		WIDOW	
WHITE		WHITE		METHODIST		HIGH SCHOOL		LABORER		YES		NO		NO	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		INJURY		POISON		OTHER	
JAN 25 1945		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		NO		NO		NO	
TIME OF DEATH		HOURS		MINUTES		P.M.		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE	
10:30		10		30		A.M.		98.6		60		20		120/80	
SIGNATURE OF PHYSICIAN		DATE		SIGNATURE OF REGISTRAR		DATE		SIGNATURE OF WITNESS		DATE		SIGNATURE OF WITNESS		DATE	
J. H. HARRIS		JAN 25 1945		J. H. HARRIS		JAN 25 1945		J. H. HARRIS		JAN 25 1945		J. H. HARRIS		JAN 25 1945	
ADDRESS OF DECEASED		CITY		STATE		COUNTRY		ADDRESS OF NEXT OF KIN		CITY		STATE		COUNTRY	
1234 E. BALTIMORE		BALTIMORE		MD		USA		1234 E. BALTIMORE		BALTIMORE		MD		USA	
DATE OF INTERVIEW		PLACE OF INTERVIEW		INTERVIEWER		DATE		INTERVIEWER		DATE		INTERVIEWER		DATE	
JAN 25 1945		BALTIMORE		J. H. HARRIS		JAN 25 1945		J. H. HARRIS		JAN 25 1945		J. H. HARRIS		JAN 25 1945	

## CERTIFICATE OF DEATH

Reg. Dist. No.

13703

13747

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Port Deposit,		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First George Middle Gray Last Gerry		4. DATE OF DEATH Month December Day 7 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/9/1883
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Slaughter House Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-03-2699	
17. INFORMANT George Maloney Gerry		Address Port Deposit	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage (b) Cerebral Sclerosis (c) Arterio-Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 days 3 yrs - 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 6 1960 to Dec 6 1960, that I last saw the deceased alive on Dec 6 1960, and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence J. Benson M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) CLARENCE J. BENSON		PORT DEPOSIT Md. 12/6/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-11-1960	22c. NAME OF CEMETERY OR CREMATORY Harmony Chapel	22d. LOCATION (City, town, or county) (State) Port Deposit Md.
23. FUNERAL DIRECTOR'S SIGNATURE Clarence M. D. Fullen Rising Sun Md.		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
DATE DEC 12 '60		Clarence S. Kraus	

1

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
1SM 9/58

STATE OF MASSACHUSETTS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

1917

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G279 1-16-61 et

## CERTIFICATE OF DEATH

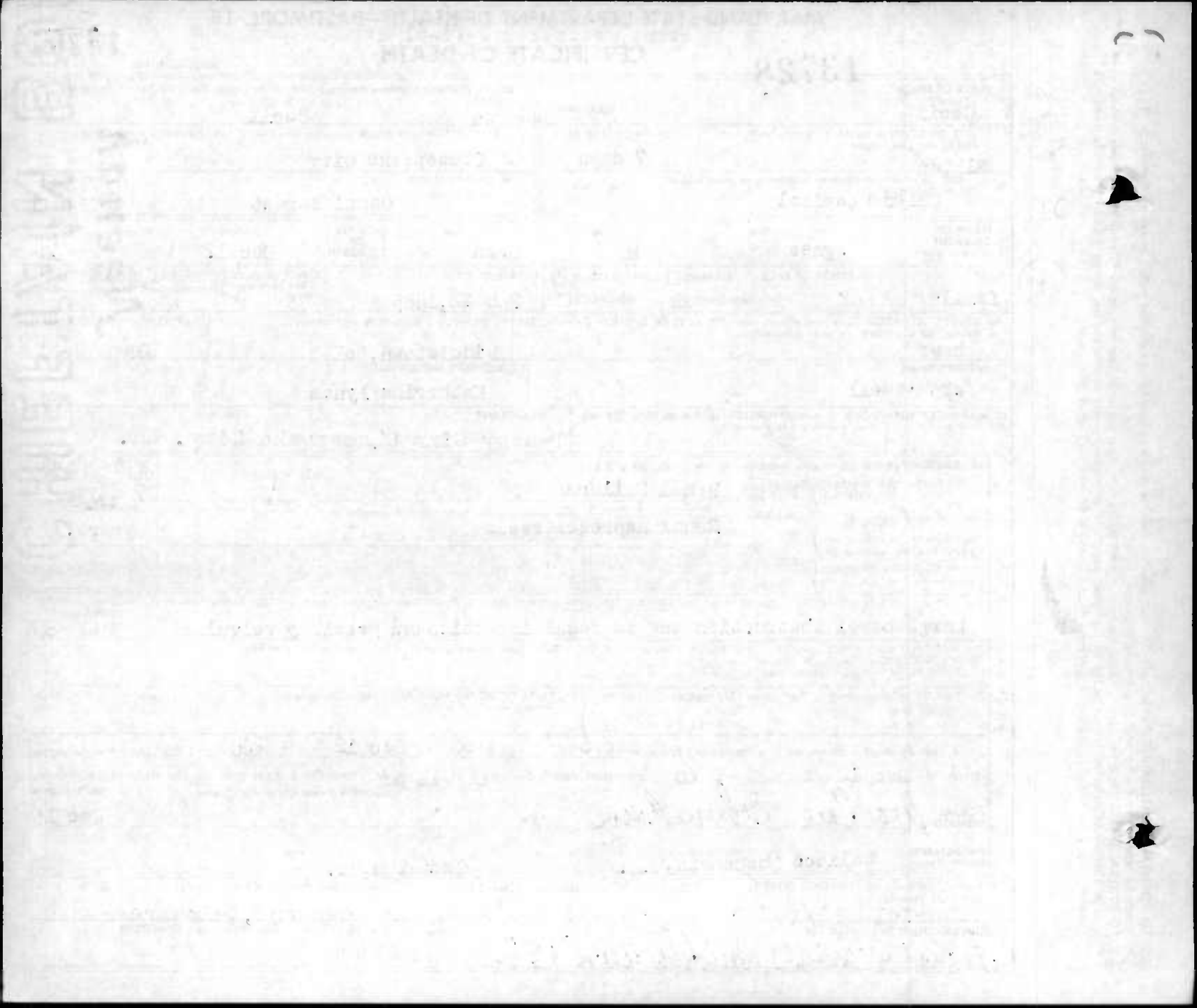
Reg. Dist. No.

13704

13728

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b> c. LENGTH OF STAY IN lb <b>7 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake City</b> d. STREET ADDRESS <b>Canal Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle <b>M</b> Last <b>Ginn</b>		4. DATE OF DEATH Month <b>Dec 12</b> Day <b>19</b> Year <b>60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 22, 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>9</b>	11. IF UNDER 24 HRS. Days <b>11</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>hswf</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Middletown, Del</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Atwell</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Lynam</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Address</b> <b>Tweety Ginn Chesapeake City, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure</b> <b>446X</b> DUE TO <b>Renal neprosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Large bowel obstruction due to fecal impaction and possibly volvulus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>Dec 6</b> , 19 <b>60</b> , to <b>Dec 12</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Dec 12</b> , 19 <b>60</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Wallace Obenshain</b> M.D.		DATE SIGNED <b>Dec 15</b>	
PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b>		ADDRESS (Street, city or town, state) <b>Cecilton, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/16/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Townsend Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Townsend, Delaware</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. Lester Daniels</b>		24a. REC'D BY REGISTRAR <b>DEC 20 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL—ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14570

13729

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS Md	
3. NAME OF DECEASED (Type or print) MARY First JANE Middle GROSS Last		4. DATE OF DEATH December 9 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1960
9. AGE (In years lost birthday) yrs. 2		10. IF UNDER 1 YEAR Months Days Hours Min 2 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STANLEY GROSS		14. MOTHER'S MAIDEN NAME MARJORIE ADAMS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —	
17. INFORMANT MR. STANLEY GROSS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Severe hydrocephalus; spina bifida IMMEDIATE CAUSE (a) 752X DUE TO (Baby lived from 1:55p.m. to 4:10p.m.) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Talipes varus, bilateral, severe INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 9 1960 to Dec. 9 1960, that I last saw the deceased alive on Dec. 9 1960, and that death occurred at 4:10p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews Jr.		DATE SIGNED 12/10/60	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR., M.D.		Elkton Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 12/11/60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery		22d. LOCATION (City, town, or county) Cecil County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Charles S. Hines	
DATE JAN 13 '61			

2065181XV4

STATEMENT OF DEATH

1923

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of declarant: [illegible]  
9. Signature of physician: [illegible]  
10. Signature of registrar: [illegible]

## CERTIFICATE OF DEATH

Reg. Dist. No.

13705

13730

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hermitage Drive		d. STREET ADDRESS Hermitage Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EMMA First Middle Last HAM		4. DATE OF DEATH December 3, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1869
9. AGE (In years lost birthday) yrs. 91		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Fox, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jackson Phipps		14. MOTHER'S MAIDEN NAME Polly Osborne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles R. Ham		Address Rising Sun, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1955, to Dec. 3, 1960, that I last saw the deceased alive on Dec. 2, 1960, and that death occurred at 10:10 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) S. RALPH A. NDREWS, Jr., M.D.		233 E. Main Street 12/4/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 7, 1960	
22c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery		22d. LOCATION (City, town, or county) (State) Rising Sun, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME Small/h. Dee Elkton, Md.		24a. REC'D BY REGISTRAR DATE DEC 8 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED NAME JACKSON, JAMES SEX Male AGE 83 DATE OF BIRTH 1880		DECEASED NAME JACKSON, JAMES SEX Male AGE 83 DATE OF BIRTH 1880	
PLACE OF BIRTH Baltimore, Md. COUNTY Baltimore		PLACE OF BIRTH Baltimore, Md. COUNTY Baltimore	
OCCUPATION Retired DATE OF DEATH 1963		OCCUPATION Retired DATE OF DEATH 1963	
PLACE OF DEATH Home ADDRESS 1234 Main St. Baltimore, Md.		PLACE OF DEATH Home ADDRESS 1234 Main St. Baltimore, Md.	
CAUSE OF DEATH Heart Disease ICD-9 CODE 410		CAUSE OF DEATH Heart Disease ICD-9 CODE 410	
MANNER OF DEATH Natural MEDICAL ATTENDANT Dr. J. H. Smith		MANNER OF DEATH Natural MEDICAL ATTENDANT Dr. J. H. Smith	
SIGNATURE OF DECEASED (None) SIGNATURE OF WITNESSES (None)		SIGNATURE OF DECEASED (None) SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN Dr. J. H. Smith DATE 1963		SIGNATURE OF PHYSICIAN Dr. J. H. Smith DATE 1963	
SIGNATURE OF REGISTRAR (None) DATE 1963		SIGNATURE OF REGISTRAR (None) DATE 1963	





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13749

13707

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>21 Elkton</b>	
f. STREET ADDRESS <b>1 241 Mackall Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HERBERT</b> Middle <b>(NMI)</b> Last <b>HAMMOND</b>		4. DATE OF DEATH Month <b>December</b> Day <b>15</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-25-93</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Landscaper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Hammond (deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Mary Goodnow (deceased)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218-09-6170</b>	
17. INFORMANT <b>Mrs. Kathryn Hammond, wife, 241 Mackall St.</b>		Address <b>Elkton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia bilateral severe unresolved</b> DUE TO <b>450.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO <b>unknown</b> (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dilating treatments for stricture of prostatic urethra</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>A.L. MOONEY</b> attended the deceased from <b>December 6, 1960</b> to <b>December 15, 1960</b> and that death occurred at <b>12:15 am</b> on the causes and on the date stated above.		22a. SIGNATURE <b>A.L. Mooney</b>	
22b. PHYSICIAN'S NAME (Type) <b>A.L. MOONEY, Asst. Clinical Pathologist, V.A. Hospital, Perry Point, Md.</b>		22c. ADDRESS <b>Cherry Hill, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 18, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Cherry Hill, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. PIPPIN &amp; SON, ELKTON, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>DEC 19 60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>		25c. DATE <b>DEC 19 60</b>	

CERTIFICATE OF DEATH

1934

Week

Month

Year

Day

Age

Sex

Color

Place of Birth

Place of Death

1934

1934

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James Bennett (Decedent)

James Bennett (Decedent)

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13731 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13708											
Item 8 Film G277 12-21-60 et											
1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b D.O.A.		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Md.		b. COUNTY Cecil			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) George E. Holmes		4. DATE OF DEATH 12 12 19 60					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1912 June 3 1922		9. AGE (In years last birth day) 48		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Thicol Cem. Plant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Grason Holmes				14. MOTHER'S MAIDEN NAME Carrie Rothwell Elkton, Md.							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 216-01-4613		17. INFORMANT Mrs. George Holmes. 69 Hollingworth Manor							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 DUE TO pancreatitis Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO Not know as to length of time condition existed PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE R.C. Dodson RISING SUN, MD. DATE SIGNED 12-13-60 EXAMINER'S NAME (Type) R.C. Dodson											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/15/60		22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception Rd #4 Elkton Md.		22d. LOCATION (City, town, or country) (State)					
23. FUNERAL DIRECTOR H. Walter Dan Boze		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		DATE DEC 15 '60					

FOR STATE  
OFFICE

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13732

## CERTIFICATE OF DEATH

Reg. Dist. No. 13709

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural North East</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>V</b> Last <b>HOUSEKEEPER</b>		4. DATE OF DEATH Month <b>12</b> Day <b>6</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 20, 1880</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Andrew Anderson</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Gardy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>		INFORMANT <b>Cheyney V. Housekeeper</b> Address <b>North East, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular failure</b> <b>443</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>C.V.A. (cerebral hemorrhage)</b> DUE TO (c) <b>Hypertension H.C.V.D.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>3 days</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>G.A.S., A.S.C.V.D.</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>Dec. 3</b> , 19 <b>60</b> , to <b>Dec. 6</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Dec 5</b> , 19 <b>60</b> , and that death occurred at <b>2.35 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cecil Ave.</b> DATE SIGNED <b>Dec 5</b>					
ACTUAL SIGNATURE <b>Luis M. Cuza</b>		PHYSICIAN'S NAME (Type) <b>Luis M. Cuza, M.D.</b> <b>North East, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-9-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary Anne's Episcopal</b>		22d. LOCATION (City, town, or county) (State) <b>North East, Cecil Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph P. Grant</b> ADDRESS <b>North East, Maryland</b>		24a. REC'D BY REGISTRAR <b>DEC 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Grant</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon between Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



13750

## CERTIFICATE OF DEATH

Reg. Dist. No. 13710

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>				c. LENGTH OF STAY IN 1b <b>X</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>H.</b> Last <b>Husfelt</b>				4. DATE OF DEATH Month <b>December</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 27, 1873</b>	9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac Husfelt</b>				14. MOTHER'S MAIDEN NAME <b>Jane Howard.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(II yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Mr. Edgar Husfelt, Cecilton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>446X</b> IMMEDIATE CAUSE (a) <b>Nephrosis</b> DUE TO <b>Nephrosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>(c)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>9 mos.</b> <b>years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 12</b> , 19 <b>60</b> , to <b>Dec 5</b> , 19 <b>60</b> that I last saw the deceased alive on <b>December 5</b> , 19 <b>60</b> , and that death occurred at <b>3:00P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cecilton, Md.</b> DATE SIGNED <b>8 Dec 60</b>							
ACTUAL SIGNATURE <b>Wallace Obenshain</b>		M.D. <b>Cecilton, Md.</b>					
PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 8, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cecilton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cecilton, Cecil Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows, Millington, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1937

Death

No.

Age

Deceased

Residence

December 31

1937

1937

at

June 17, 1937

at

June 17, 1937

at

John Howard

John Howard

John Howard

John Howard

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June 17, 1937

June 17, 1937

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211

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13734

CERTIFICATE OF DEATH

Reg. Dist. No.

13712

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>222 East Main Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY HOLLINGSWORTH JAMAR</b>		4. DATE OF DEATH <b>December 6, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 6, 1873</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Elkton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John H. Jamar</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Hollingsworth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. R. H. Blanchard</b>		Address <b>Evanston, Ill.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>442x</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular renal disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arthritis, severe</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 20, 1957</b> , to <b>Dec. 6, 1960</b> , that I last saw the deceased alive on <b>Dec. 6, 1960</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>233 E. Main Street</b> DATE SIGNED <b>12/6/60</b>			
ACTUAL SIGNATURE <b>S. RALPH ANDREWS, JR.</b> M.D.		ADDRESS <b>Elkton, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>S. RALPH ANDREWS, JR., M.D.</b>		ADDRESS <b>Elkton, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 8, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Presbyterian Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Elkton, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b> ADDRESS <b>Elkton, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 8 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

MEDICAL CERTIFICATION

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13721 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13714											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Md. b. COUNTY Cecil					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake City						c. LENGTH OF STAY IN 1b all life					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS Chesapeake City					
3. NAME OF DECEASED (Type or print) Peter Kamit						4. DATE OF DEATH Month 12 Day 8 Year 19 60					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-12-1883		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.				11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME no information						14. MOTHER'S MAIDEN NAME no information					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Peter Kamit, Chesapeake City, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE R.C. Dodson						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) R.C. Dodson						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						Address (Street, city, town, or county) Rising Sun, Md. 12-8-60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 12-12-60		22c. NAME OF CEMETERY OR CREMATORY St. Roses Cemetery			22d. LOCATION (City, town, or country) (State) Chesapeake City, Md.			
23. FUNERAL DIRECTOR ADDRESS PIPPIN FUNERAL HOME Donald M. Dee Elkton, Md.						24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur L. Francis					

DEC 14 '60

1948

DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
STATE OF NEW YORK  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13752

CERTIFICATE OF DEATH

13715

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville,</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 16 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VAH., Perry Point, Md.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington,</b>	
f. STREET ADDRESS <b>2229 13th Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Andrew</b> Middle <b>James</b> Last <b>KENNEY</b>		4. DATE OF DEATH Month <b>December</b> Day <b>18.</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-11-11</b>
9. AGE (In years lost birthday) yrs. <b>47</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>7</b> Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Keswick, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew KENNEY</b>		14. MOTHER'S MAIDEN NAME <b>Lillian James.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>577-28-8470</b>	
17. INFORMANT <b>Hospital records - Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningeal hemorrhage of undetermined origin</b> <b>331X</b> DUE TO <b>(subarachnoid hemorrhage) massive.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>VAH</b> (hospital) attended the deceased from <b>October 31, 1960</b> to <b>Dec. 13, 1960</b> and that death occurred at <b>10:30</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>a. L. mooney</b>		22b. DATE SIGNED <b>12-19-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. L. MOONEY, M.D., Asst. Pathologist, VAH, Perry Point, Md.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>12/23/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Ft. Myers, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SON, Havre de Grace, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 28 1960</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles E. Harris</b>			

1875

CERTIFICATE OF DEATH

1875



STATE OF TEXAS, COUNTY OF DALLAS

I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 1st day of January, 1900, at the City of Dallas, Texas, I attended the last illness of

John Doe, who died at the residence of the deceased, at the age of 45 years, of the disease of

the heart, and that the death was caused by the disease of the heart, and that the deceased was not suffering from any contagious or infectious disease at the time of death.

Witness my hand and the seal of my office, this 1st day of January, 1900.

Signature of Physician

Notary Public for the State of Texas

1-19-00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13716

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>35yrs.6mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1801 E. Fairmount Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ALEXANDER</b> Middle <b>(NMI)</b> Last <b>KORNILUK</b>				4. DATE OF DEATH Month <b>December</b> Day <b>25</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-21-88</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min.		IF UNDER 24 HRS. Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>(Not available)</b>				14. MOTHER'S MAIDEN NAME <b>(Not available)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary thrombosis</b> DUE TO <b>4 days</b> (c) <b>Arteriosclerotic heart disease</b> <b>unknown</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>4 days</b> <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary tuberculosis inactive</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>VA</b> 19 p. m. <b>VA</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <del>XXXXXX</del> attended the deceased from <b>June 26</b> , 19 <b>60</b> , to <b>December 25, 1960</b> and that death occurred at <b>7</b> PM, from the causes and on the date stated above.							
22a. SIGNATURE <b>A. L. MOONEY</b>				22b. DATE SIGNED <b>12-28-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>A. L. MOONEY</b>				22d. ADDRESS <b>Asst. Clinical Pathologist, VAH, Perry Point, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>				23b. DATE THEREOF <b>12/30/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robbington &amp; Son</b>				ADDRESS <b>Havre de Grace, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 5 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>							

1875

CERTIFICATE OF DEATH

1875

NAME

AGE

SEX

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE

TIME

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DATE

TIME

PLACE

NAME

AGE

SEX

(Not available)

(Not available)

DATE OF DEATH

TIME

PLACE

CAUSE OF DEATH

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REMARKS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13717

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural. Life		c. LENGTH OF STAY IN 1b X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Woodlawn Rd.		d. STREET ADDRESS 1 Woodlawn Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ruby Christine Land		4. DATE OF DEATH Month Day Year Dec. 18 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1960
9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 19	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Charlie A. Land		14. MOTHER'S MAIDEN NAME Elizabeth Truslow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Charlie A. Land, Port Deposit, Md. Rural		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.0 DUE TO Acute Gastro Enteritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 15 1960 to Dec 18 1960, that (I) (we) last saw the deceased alive on Dec 18 1960, and that death occurred at 9 AM, from the causes and on the date stated above.			
22a. SIGNATURE Clarence I. Benson		22b. DATE SIGNED 12/18/60	
22c. PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.		22d. ADDRESS Port Deposit, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-19-1960	
23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son		25a. REC'D BY REGISTRAR DATE DEC 20 '60	
ADDRESS Perryville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kinne	

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1917

DATE OF DEATH: 1917

AGE: 19

SEX: M

RACE: W

CAUSE OF DEATH: 1917

PLACE OF DEATH: 1917

SIGNATURE: 1917

DATE: 1917

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		MARYLAND c. LENGTH OF STAY IN 1b <b>35yrs. 5mo. 17days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Enterprise</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>85X-3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>A.</b> Last <b>LAULIS</b>		4. DATE OF DEATH Month <b>December</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-?-95</b>	9. AGE (In years last birthday) <b>65</b> yrs.	10. IF UNDER 1 YEAR Months <b>65</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>L. A. LAULIS (DECEASED)</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mrs. Ruth Long, sister, Enterprise, W. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis generalized</b> DUE TO (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>VA</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Enterprise</b>		(County) <b>W. Va.</b>		(State) <b>W. Va.</b>	
21. I certify that <del>XXXXX</del> (hospital) attended the deceased from <b>June 26</b> 19 <b>25</b> to <b>December 13</b> 19 <b>60</b> and that death occurred at <b>6:30am</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>W.M. HARRIS</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12-14-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>W.M. HARRIS</b>		22d. ADDRESS <b>V.A. Hospital, Perry Point, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>12/14/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>	
23d. LOCATION (City, town, or county) <b>Chambers, W. Va.</b>		(State) <b>W. Va.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bennington &amp; Son</b>		ADDRESS <b>Bennington &amp; Son, Havre de Grace, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 22 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>					

CERTIFICATE OF DEATH

1885

West Virginia

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

13755

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13719

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 2 mo. 26 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL (NMI) MILLER		4. DATE OF DEATH Month Day Year December 2 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-10-07
9. AGE (In years lost birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY VA Senate Bldg.	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Miller (deceased)		14. MOTHER'S MAIDEN NAME Fannie Hogan (deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address N.E. Wash. D. C. Joseph M. Miller, brother, 5368 Chillum Pl.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Debilitation And Emaciation. 177X DUE TO Widespread Metastasis (b) DUE TO Carcinoma Of Prostate (c) 5 Months 7 Months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (X) (MRS. MOONEY) attended the deceased from September 6, 1960, to December 2, 1960, and that death occurred at 6:05 AM from the causes and on the date stated above.	
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 12/7/1960	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		25a. REC'D BY REGISTRAR DATE DEC 12 '60	
25b. REGISTRAR'S SIGNATURE Catherine L. Hanks		25c. HAVRE DE GRACE	

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
ALBANY, N. Y.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13720

13735

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, indicate before admission) o. STATE <del>Delaware</del> b. COUNTY <del>Delaware</del>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>Wilmington</del> Salem	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 327 New Market St. 67X-3	
3. NAME OF DECEASED (Type or print) First Middle Last Rose Ella Myers		4. DATE OF DEATH Month Day Year Dec. 17 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1873
9. AGE (In years lost birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Mc Pherson		14. MOTHER'S MAIDEN NAME No Info.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Herbert Jobson Wilm. Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Insufficiency (c) Coronary Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 1 week 1 week 1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/7, 19 60, to 12/17, 19 60, that I last saw the deceased alive on 12/17, 19 60, and that death occurred at 3:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph G. Lanzi M.D.		ADDRESS (Street, city or town, state) Main St Elkton Md 2160	
PHYSICIAN'S NAME (Type) Joseph G. Lanzi			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 20, 1960	22c. NAME OF CEMETERY OR CREMATORY East View Cemetery	22d. LOCATION (City, town, or county) (State) Salem, New Jersey
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME Joseph M. Due Elkton, Md.		24a. REC'D BY REGISTRAR DATE DEC 28 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13721

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WINSOR</b> First Middle Last <b>MYERS</b>		4. DATE OF DEATH Month <b>Dec</b> Day <b>8</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/12/00</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Projectionist (ret)</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Havre de Grace, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert S. Myers</b>		14. MOTHER'S MAIDEN NAME <b>Beuhla D. Ricketts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>213-30-7426</b>	
17. INFORMANT <b>Lillian Myers, 253 Locust Lane, Elkton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction due to</b> <b>420.0</b> DUE TO <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>S. GOLDBRABEN</b> attended the deceased from <b>November 27, 1960</b> to <b>December 8, 1960</b> and that death occurred at <b>11:25 am</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>S. GOLDBRABEN</b>		22b. DATE SIGNED <b>12-8-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. GOLDBRABEN, M.D., Chief, Medical Svc. VAH, Perry Point, Md.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-11-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Charlestown</b>		23d. LOCATION (City, town, or county) (State) <b>Charlestown Cecil Co. Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Grants Funeral Home, North East, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 12 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>			

STATE OF TEXAS  
COUNTY OF DALLAS

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

13722

13757

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>HARFORD</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RISING SUN, RURAL</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ABERDEEN</b> <b>1231-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GRAVEYAL NURSING HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>HOLLINBERGER</b> Last <b>NICKLAS</b>				4. DATE OF DEATH Month <b>12</b> Day <b>23</b> Year <b>1960</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 / 21 / 1870</b>		9. AGE (In years last birthday) yrs. <b>90</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE RET.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM A. HOLLINBERGER</b>				14. MOTHER'S MAIDEN NAME <b>SARAH J. WEAVER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MRS. GEO. L. SCHINDEL ABERDEEN, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC MYOCARDITES</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SENILITY</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 1</b> , 19 <b>57</b> , to <b>Dec 22</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Dec 23</b> , 19 <b>60</b> , and that death occurred at <b>4 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>RISING SUN, MD.</b> DATE SIGNED <b>12/23/60</b> ACTUAL SIGNATURE <b>R. C. DODSON</b> M.D. <b>RISING SUN, MD.</b> <b>12/23/60</b> PHYSICIAN'S NAME (Type) <b>R. C. DODSON</b> <b>RISING SUN, MD.</b> <b>12/23/60</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/26/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR GROVE CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>CHAMBERSBURG PA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas M. McElb.</b>				ADDRESS <b>RISING SUN, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 27 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

13723

13736

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Galena</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Devine Nursing Home</b>		d. STREET ADDRESS <b>1482</b>	
3. NAME OF DECEASED (Type or print) First <b>Wilbur</b> Middle <b>Petticord</b> Last <b>Petticord</b>		4. DATE OF DEATH Month <b>December</b> Day <b>30</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August, 28, 1864</b>
9. AGE (In years lost birthday) yrs. <b>96</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Brick Mason</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brick Mason</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>Miss, Selma Scotten,</b>	
17. INFORMANT <b>Galena, Md. Kent Co.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> DUE TO <b>465X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility, Completely bed-fast past two years. Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug</b> , 19 <b>60</b> , to <b>30 Dec</b> , 19 <b>60</b> that I last saw the deceased alive on <b>30 Dec</b> , 19 <b>60</b> , and that death occurred at <b>9:00AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Wallace Obenshain</b> M.D. <b>31 Dec 60</b>			
ACTUAL SIGNATURE <b>Wallace Obenshain</b> M.D. <b>31 Dec 60</b>			
PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b> <b>Cecilton, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 3, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Galena Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Galena, Kent Co; Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 4 '61</b>	
ADDRESS <b>Millington, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1938

STATE OF CALIFORNIA

1938

County of ...  
City of ...  
State of California  
I, the undersigned, Clerk of the County of ...  
do hereby certify that ...  
Witness my hand and seal of office this ... day of ... 1938.  
Clerk of the County of ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

13758

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13724

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>11 W. Forrest Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>E.</b> Last <b>PETTIT</b>		4. DATE OF DEATH Month <b>December</b> Day <b>11</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1-14-91</b>
9. AGE (In years lost birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph E. Pettit (deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Martha E. Beach (deceased)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>296-05-9003</b>	
17. INFORMANT <b>Mrs. Edith Conlon, niece, 11 W. Forrest St. Alexandria, Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic tumor to brain and brain stem</b> DUE TO (c) <b>Malignant melanoma of skin</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>2 weeks</b> <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>VA</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>XXXXX</del> <b>XXXXX</b> (the hospital) attended the deceased from <b>August 24, 19 60</b> to <b>December 11, 19 60</b> and that death occurred at <b>6:40pm</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>A. L. Mooney</b>		22b. DATE SIGNED <b>12-12-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. L. MOONEY, Asst. Clinical Pathologist, V. A. Hospital, Perry Point, Md.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>12/13/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Union</b>		23d. LOCATION (City, town, or county) (State) <b>South Alexandria, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son, Havre de Grace, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 15 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Clotburg &amp; Finner</b>			

1938

CERTIFICATE OF DEATH

1938

Virginia

Death

Albemarle

Dec. 1938

Forty

11 E. Forest Street

Voluntary Administration Hospital

November 11

White

White

1938

1-1-38

White

Male

1938

Virginia

Albemarle

Attendant

Joseph A. Feltz (deceased), Martha A. Feltz (deceased)

11 E. Forest Street, Albemarle, Virginia

John

Infantile amnesia to birth and brain death

Infantile amnesia to birth and brain death

11 E. Forest Street, Albemarle, Virginia

11-1-38

11-1-38

11 E. Forest Street, Albemarle, Virginia

11 E. Forest Street, Albemarle, Virginia

Union

11 E. Forest Street, Albemarle, Virginia

1  
FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 13750 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13725

1. PLACE OF DEATH e. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE	
Cecil MARYLAND		Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
Perry Point		Havre de Grace	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
Veterans Administration Hospital		Old Post Road	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
MERHL D. RITCHIE		December 11 1960	
5. SEX		6. COLOR OR RACE	
Male White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Machine Operator		Assembler	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Cyrus E. Ritchie (deceased)		Ella R. Scarff (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
Yes WW II		unknown	
17. INFORMANT		Address	
Martin Ritchie, brother, 1308 N. Market St.		Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia		2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic emphysema		Years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. C. DODSON		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. DODSON, Rising Sun, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED 12-12-60	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
REMOVAL 12/13/1960		22c. NAME OF CEMETERY OR CREMATORY	
		Mt. Olive	
23. FUNERAL DIRECTOR		22d. LOCATION (City, town, or country) (State)	
Pannington & Son, Havre de Grace, Md.		Frederick, Maryland	
ADDRESS		24a. REC'D BY REGISTRAR	
		24b. REGISTRAR'S SIGNATURE	
		DATE DEC 15 '60	

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13737

## CERTIFICATE OF DEATH

13726

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Elkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>-</u> Last <u>Roland</u>				4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1891</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Spacey</u>				14. MOTHER'S MAIDEN NAME <u>Martha Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mrs Ted Marcum Elkton R.D.3 Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus Ulcers; Diabetic Mellitus.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u>		(County) <u>  </u> (State) <u>  </u>	
21. I certify that I attended the deceased from <u>11/26</u> , 19 <u>60</u> , to <u>12/7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12/7/60</u> , 19 <u>  </u> , and that death occurred at <u>9:20 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Klaus H. Huchner</u>		M.D. <u>North East, Md</u>		ADDRESS (Street, city or town, state) <u>  </u>		DATE SIGNED <u>12/7/60</u>	
PHYSICIAN'S NAME (Type) <u>Klaus H. Huchner M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>12-8-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Richland</u>		22d. LOCATION (City, town, or county) (State) <u>Richland, Tazewell Co., Va</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph A. Grant</u>		ADDRESS <u>North East, Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18-Baltimore-Health Department of State Maryland  
 1937  
 CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1892</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 10 1915</i>		9. PLACE OF MARRIAGE <i>St. Louis, Mo.</i>		10. NAME OF SPOUSE <i>Jane Doe</i>		11. DATE OF DEATH <i>Dec 10 1937</i>		12. PLACE OF DEATH <i>St. Louis, Mo.</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. DISEASE OR INJURY <i>Myocardial Infarction</i>		15. DATE OF ONSET <i>Nov 15 1937</i>		16. PLACE OF ONSET <i>St. Louis, Mo.</i>		17. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>		18. DATE OF EXAMINATION <i>Dec 10 1937</i>	
19. SIGNATURE OF PHYSICIAN <i>J. H. Smith</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>Jane Doe</i>		22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>Jane Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	

1937  
 18-Baltimore-Health Department of State Maryland  
 1937  
 CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13738

CERTIFICATE OF DEATH

Reg. Dist. No.

13727

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>516 North Street</u>		d. STREET ADDRESS <u>516 North Street</u>	
3. NAME OF DECEASED (Type or print) First <u>TOBIAS</u> Middle <u>RUDOLPH</u> Last <u>RUDOLPH</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>25</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 13, 1892</u>
9. AGE (In years last birthday) yrs. <u>68</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Concrete</u>	
11. BIRTHPLACE (State or foreign country) <u>Elkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles C. Rudolph</u>		14. MOTHER'S MAIDEN NAME <u>Mary V. White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-07-2661</u>	
17. INFORMANT <u>Mrs. Hilda M. Rudolph, Elkton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>443 X</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>4 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic respiratory infection</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 22, 1960</u> to <u>Dec 25, 1960</u> , that I last saw the deceased alive on <u>Dec 25, 1960</u> , and that death occurred at <u>2:47 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Tillman D. Johnson M.D.</u>		ADDRESS (Street, city or town, state) <u>123 Singers Ave</u>	
PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson M.D.</u>		DATE SIGNED <u>12-27-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-28-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>		ADDRESS <u>Donald H. Dee Elkton,</u>	
24a. REC'D BY REGISTRAR <u>DEC 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur P. H.</u>	

CERTIFICATE OF DEATH

1913

THE DAY

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		45		M		W		1868		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
Carpenter		Heart Disease		Natural		Several Months		April 10, 1913		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
FATHER'S NAME		MOTHER'S NAME		SPOUSE'S NAME		DATE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		1880		April 10, 1913		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
EDUCATION		RELIGION		POLITICAL PARTY		MILITARY SERVICE		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
High School		Roman Catholic		Democratic		None		April 10, 1913		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
PREVIOUS ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
None		April 10, 1913		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		CITY		COUNTY		STATE		STATE	
April 10, 1913		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		CITY		COUNTY		STATE		STATE	
April 10, 1913		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	

THE ABOVE IS A TRUE AND CORRECT STATEMENT OF THE FACTS CONCERNING THE DEATH OF THE ABOVE NAMED PERSON.

13739

CERTIFICATE OF DEATH

Reg. Dist. No.

13728

1. PLACE OF DEATH o. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Scott</i> Last <i>Scott</i>		4. DATE OF DEATH Month <i>12</i> Day <i>2</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 22, 1887</i>
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Peter Cobbs</i>		14. MOTHER'S MAIDEN NAME <i>Lizzie (no record)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs. John S. Scott, Jr. Charlestown, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Parenchymatous Nephritis</i> DUE TO (c) <i>Aortic Insufficiency</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2- Days</i> <i>3- Years</i> <i>5-Years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/27</i> , 19 <i>60</i> to <i>12/2</i> , 19 <i>60</i> that I last saw the deceased alive on <i>12/1</i> , 1960, and that death occurred at <i>9:15 A</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>245 East High Street</i> DATE SIGNED <i>12/2/60</i>			
ACTUAL SIGNATURE <i>James L. Johnson</i> M.D.		DATE SIGNED <i>12/2/60</i>	
PHYSICIAN'S NAME (Type) <i>James L. Johnson M. D.</i>		Elkton Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	22b. DATE THEREOF <i>12-3-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Bethel G. M. E. Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Willow County, South Carolina</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E. Bullak</i>		ADDRESS <i>Hammond Place, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>DEC 6 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13729

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE b. COUNTY	
Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CONOWINGO, RURAL		MARYLAND CECIL	
c. LENGTH OF STAY IN 1b ALL LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CONOWINGO	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last CHESTER ABRAHAM SIDWELL		Month Day Year 12 11 1960	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-1891
M W	W		9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer U.S. Gov.		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Curtis Sidwell		14. MOTHER'S MAIDEN NAME Eddie Bunney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 222-18-5073	
17. INFORMANT Mrs. Chester Sidwell. Conowingo. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12-13-60	
R.C. Dodson Rising Sun, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		12-15-60	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Conowingo Bapt.		Conowingo Md.	
23. FUNERAL DIRECTOR E. M. Mullen		24a. REC'D BY REGISTRAR DEC 15 '60	
Rising Sun, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

OR SIGN  
HEALTH UNIT

RECEIVED  
JAN 19 1964  
U.S. AIR FORCE  
MEDICAL CENTER  
DAVIS, CALIF.

TO: DIRECTOR, U.S. AIR FORCE  
FROM: [illegible]  
SUBJECT: [illegible]

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100. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13761

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13730

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>5 mo. 3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>1340 S. Hanover</b>			
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>W.</b> Last <b>SMITH</b>				4. DATE OF DEATH Month <b>December</b> Day <b>14</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-24-27</b>	9. AGE (In years lost birthday) <b>33</b> yrs.	IF UNDER 1 YEAR Months <b>33</b> Days <b>33</b> Hours <b>33</b> Min.	IF UNDER 24 HRS. Hours <b>33</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter's Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis Smith</b>				14. MOTHER'S MAIDEN NAME <b>Mary Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>219-20-603</b>		17. INFORMANT <b>Mrs. Mary Hill, Mother, 1340 S. Hanover St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia due to aspiration of foreign substance (food)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Brain Syndrome associated with Parkinsonian/Syndrome with mental and physical deterioration, severe.</b> DUE TO like (c) <b>Unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>J. L. Garey</b> attended the deceased from <b>July 11</b> 19 <b>60</b> to <b>December 14</b> 19 <b>60</b> and that death occurred <b>11:30pm</b> on the date stated above.							
22a. SIGNATURE <b>J. L. Garey</b>				22b. DATE SIGNED <b>12-15-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>J. L. GAREY Clinical Pathologist, V.A. Hospital, Perry Point, Md.</b>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		23b. DATE THEREOF <b>12/19/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glenhaven</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Home, 130 E. Fort Ave.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 19 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

Baltimore, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/59

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Item 1 Film 276 12-16-60 et

13731

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland		c. LENGTH OF STAY IN 1b 51 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 3304 Clifton Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle D. Last STEWART		4. DATE OF DEATH Month 12 Day 4 Year 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-28-98
9. AGE (In years lost birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (Government)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John T. Stewart (deceased)		14. MOTHER'S MAIDEN NAME Katie/or Kathryn Wallace (deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-1 216 16 2541	
17. INFORMANT Mrs. Grace J. Stewart (Wife)		Address 3304 Clifton Ave., Balto, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Exacerbation Of Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerosis, generalized		INTERVAL BETWEEN ONSET AND DEATH 7 Hours 2 Years Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 10-14-1960 to 12-4-1960, and that death occurred at 12:05 PM from the causes and on the date stated above.		22a. SIGNATURE A.L. Mooney	
22b. DATE 12-4-60		22c. PHYSICIAN'S NAME (Type) A.L. MOONEY, M.D.	
22d. ADDRESS VAH, PERRY POINT, MARYLAND		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-9-60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hemsley Funeral Home, 578 W. Biddle St. Balto. Md.		25. REC'D BY REGISTRAR DATE DEC 8 '60	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

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03-2-21

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may be received by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13763

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13732

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>8 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>112 Bridge Street</b>			
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>(NMI)</b> Last <b>THIELKER</b>				4. DATE OF DEATH Month <b>December</b> Day <b>1</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-1-95</b>	9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Thielker (deceased)</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW I 215-34-5444</b>		17. INFORMANT <b>Peterhkeepsie, N.Y. August F. Thielker, brother, 78 S. Hamilton St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Calcified Aortic Stenosis, Severe</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 Days</b> <b>Unknown</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <del>the deceased</del> attended the deceased from <b>November 23 19 60</b> to <b>December 1 19 60</b> and that death occurred <b>3:35 PM</b> from the causes and on the date stated above.							22b. DATE SIGNED <b>12-3-60</b>
22a. SIGNATURE <b>A.L. Mooney</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <b>A.L. MOONEY</b>		22d. ADDRESS <b>Asst. Clinical Pathologist, VAH, Perry Point, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>12/7/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Perminington &amp; Son</b>		ADDRESS <b>Havre de Grace, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 12 '60</b>		25b. REGISTRAR'S SIGNATURE <b>L. K. K...</b>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13733

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>HARFORD</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Calvary</i>		c. LENGTH OF STAY IN 1b <i>6 WEEKS</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Graysbrook Nursing Home</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAYRE DE GRACE 12241</i>	
d. STREET ADDRESS <i>502 So. Union Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>WILLIAM</i> Middle <i>WASHINGTON</i> Last <i>WALKER</i>		4. DATE OF DEATH <i>DEC. 9 1960</i> Month <i>DEC</i> Day <i>9</i> Year <i>1960</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>SEPT. 13, 1872</i>
9. AGE (In years last birthday) <i>88</i> yrs.		10. IF UNDER 1 YEAR Months <i>8</i> Days <i>8</i> Hours <i>8</i> Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - MAIL MESSENGER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>POST OFFICE</i>	
11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>THOMAS WALKER</i>		14. MOTHER'S MAIDEN NAME <i>MARY GILLIS</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs. Margaret F. Coakley</i> Address <i>HAYRE DE GRACE, MD.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>450.0</i> IMMEDIATE CAUSE (a) <i>Cardiac decompensation</i> DUE TO <i>Generalized arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>2 yrs.</i> (c) <i>2 yrs.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>11/15</i> <i>1960</i> , to <i>12/9</i> <i>1960</i> , that (I) (we) last saw the deceased alive on <i>12/9</i> <i>1960</i> , and that death occurred at <i>4:30</i> M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Neil Taylor Jr.</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Neil Taylor Jr.</i>		22d. ADDRESS <i>Rising Sun, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>DEC. 12, 1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>ANGEL HILL CEM.</i>		23d. LOCATION (City, town, or county) (State) <i>HAYRE DE GRACE MD</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. Madison Mitchell</i> ADDRESS <i>HAYRE DE GRACE MD</i>		25a. REC'D BY REGISTRAR <i>DEC 14 '60</i> DATE	
		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	



## CERTIFICATE OF DEATH

13734

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Martha</b> First <b>B.</b> Middle <b>Young</b> Last		4. DATE OF DEATH <b>December</b> <b>24</b> <b>1960</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b> <b>Approx.</b> <b>74</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Ella Edwards, 516 N. Holly St; Phila. 4, Pa.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary adenomatosis</b> <b>231X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Advanced senility and generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6 Dec</b> , 19 <b>60</b> , to <b>24 Dec</b> , 1960, that I last saw the deceased alive on <b>24 Dec</b> , 19 <b>60</b> , and that death occurred at <b>9 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cecilton, Cecil Co. Md.</b> DATE SIGNED <b>29 Dec 60</b>			
ACTUAL SIGNATURE <b>Wallace Obenshain</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b> <b>Cecilton, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 29, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cecilton Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cecilton, Cecil Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward J. Fellows</b>		24a. REC'D BY REGISTRAR <b>JAN 3 '61</b> ADDRESS <b>Mellington, Md.</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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